State of California Department of Consumer Affairs

PHYSICAL THERAPY BOARD of CALIFORNIA
1418 HOWE AVENUE, SUITE 16, SACRAMENTO, CA 95825-3203
TELEPHONE: (916) 561-8200

QUARTERLY REPORT AND/OR WAIVER REQUEST

FOR FOREIGN PHYSICAL THERAPIST SCHOOL GRADUATES

Section 2653(a)(3) of the Business and Professions Code states in part ... "an applicant who was issued a diploma by a physical therapy school not located in the United States shall complete a period of clinical service under the direct and immediate supervision of a physical therapist licensed by the board. **During the period of clinical service until he or she is issued a license as a physical therapist by the board, the applicant shall be identified as a "physical therapist license applicant".**

INSTRUCTIONS: This form to be completed by supervisor only. Please indicate below which report this document represents. If this form is for the quarterly report it must be completed for each quarter (12 weeks) of supervision. If this is a quarterly report **AND** a request for waiver of any further clinical services, please indicate. If space provided is insufficient, attach additional sheets of paper. Please respond to each question. All forms received incomplete will be returned.

☐ Quarterly Report (complete sections A, B & C only) ☐ Waiver of Physical Therapy Service (complete entire form)

Quarterly Report and/or Waiver Request Form must be received within 15 days of completion of each quarter.

SECTION A

Full Name: _____ (Last) _____ (First) _____ (Middle)

Address: _____ (Street) _____ (City) _____ (State) _____ (Zip Code)

Name of Physical Therapy School (include country): _____

_____

Degree and year of graduation: _____

Has the applicant passed the written exam? ☐ No ☐ Yes If yes, when: _____

Is the applicant licensed in another state(s)? ☐ No ☐ Yes If yes, which state(s): _____

Name of Facility: _____ ( ) _____ (Telephone Number)

Address: _____ (Street) _____ (City) _____ (State) _____ (Zip Code)

Date Facility was approved: (For California approved facilities only): _____

Name of person who initially applied for facility approval to supervise foreign educated physical therapist(s): _____
(For California approved facilities only)

Direct Supervisor's Name: _____ (Please print) (Last) (First) (Middle) (PT License Number/Exp. Date)

Qualifications of Direct Supervisor: _____
(Please attach a resume to first Quarterly Report)

Period covered by this report: From _____ (Month) (Day) (Year) To _____ (Month) (Day) (Year)

SECTION B

Describe how the applicant is supervised and method used to document competencies (Attach copy of completed Evaluative Tool):

_____

_____

Does the quality of the service rendered indicate that the physical therapy preparation is satisfactory? ☐ Yes ☐ No

What are the professional weak points, if any? _____

_____

Able to evaluate patient and initiate treatment plan? ☐ Yes ☐ No

Attentive to duties? ☐ Yes ☐ No

Cooperative with members of the health team? ☐ Yes ☐ No

Interested in duties? ☐ Yes ☐ No

If NO, please explain on a separate sheet of paper.

F1C

SECTION C

Character of service rendered: ☐ Satisfactory ☐ Unsatisfactory

Personal conduct (explain fully): _____

_____

Nature of professional experience and service afforded this person. Indicate total number of hours **(Not a percentage of time)** served in each department (i.e. 9 months=1400 hrs; 6 months=936 hrs; 3 months=468 hrs):

Medicine _____ Cardiopulmonary _____ Neurology _____ Surgery _____

Pediatrics _____ Orthopedics _____ Geriatrics _____ Other _____

Was this period of service on a full time basis? ☐ Yes ☐ No If NO, how many hours per week? _____

SECTION D

Service in this facility began: _____ and ended _____
month day year month day year

Name and position of direct supervisor: _____

Describe briefly, manner of "direct and immediate supervision." _____

_____

List educational experiences offered applicant (i.e. in service, classes, etc.): _____

_____

Name of Director or Chief of Physicl TherapyDept.: _____

At this time, has the applicant completed: ☐ 3 months ☐ 6 months ☐ 9 months

Does the quality of the physical therapist service indicate that the physical therapy preparation is satisfactory? ☐ Yes ☐ No

Do you recommend the applicant for licensure? ☐ Yes ☐ No

Please explain, in detail, why or why not you recommend this applicant for licensure. Attach any documentation that will support this request for waiver .

_____

_____

Remarks or suggestions regarding the applicant: _____

_____

The Physical Therapy Board will take into consideration the recommendation for licensure. Please allow three weeks for processing of this request for waiver of further clinical service.

I do herewith state that I am the person whose signature is affixed below and that all statements made are true, and understand that misstatements or omissions of material facts may be cause for denial of this application or invalidation of any such approval.

I certify under penalty of perjury under the laws of the State of California that the foregoing is true and correct and that I have been the physical therapist directly supervising the foreign educated applicants clinical service.

_____
Name of Facility

_____
Address

_____
Signature of Direct Supervisor **(blue ink only)** Official Title Date

INFORMATION COLLECTION AND ACCESS

The Physical Therapy Board of California's Executive Officer is the person who is responsible for information maintenance. Business and Professions Code Section 2632 and 2634 are the authorities which authorize the maintenance of the information. All information is mandatory. Failure to provide any of the mandatory information will result in the application being rejected as incomplete. The information provided will be used to determine qualification for licensure and admittance to the examination. Each individual has the right to review his or her file maintained by the agency subject to the provisions of the Information Practices Act.